Linking Behavioral Health and Primary Care Services to Adults with Serious Mental Illnesses

Mid-Atlantic Health Leadership Institute
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Team 5 – Project:
Linking Behavioral Health and Primary Care Services to Adults with Serious Mental Illnesses

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In the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council's thirteenth technical report titled" *Morbidity and Mortality in People with Serious Mental Illness (SMI)"*, it was revealed that, people with SMI die, on an average, 25 years earlier than the general population. The report also states that 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary, and infectious diseases.[1]

Many studies at the national and state levels support the need for bridging the gap of behavioral health and primary care. In a previous technical report published by NASMHPD Medical Directors Council: "*Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities*", January 2005, persons with serious mental illness frequently have difficulty accessing health, dental, and vision services and often rely on emergency rooms (ERs) for their care, which burdens the ER system results in discontinuous care for the individuals, and may contribute to polypharmacy issues.[2]

This report will highlight the Mid-Atlantic Health Leadership Institute (MHLI) Team's consensus on objectives and proposed recommendations identified from national and state studies to address improve linkages and the promotion integration of behavioral health and primary care services to individuals with serious mental illnesses.
The following objectives were identified:

- Increase awareness of primary care providers, health educators, and patients, consumers, family members and advocates about mental health diagnoses, treatment, and risks of treatment for individuals with serious mental illness (SMI).
- Promote integration of somatic and behavioral health care within community health centers, and outpatient mental health centers (OMHCs).
- Advocate for improved and increased behavioral health and somatic care in clinical settings (i.e., OMHCs).

Additionally, this report will identify existing activities and initiatives that contribute to improving integrated care in public health systems.

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[1] *Morbidity and Mortality in People with Serious Mental Illness*, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, October 2006; p5.

[2] : "*Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities*", National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, January 2005

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For the purposes of understanding one of the priority populations served in the public mental health system, a brief definition of serious mental illness is presented. According to Epstein J., Barker, P., Vorburger, M., & Murtha, C. (2004). *Serious mental illness and its co-occurrence with substance use disorders, 2002* (DHHS Publication No. SMA 04-3905, Analytic Series A-24). Rockville, MD: Substance Abuse and Mental Health Services Administrations, Office of Applied Studies "Estimates of the prevalence of serious mental illness (SMI) provide a measure of the population with the most severe mental health problems and indicated those persons who are most in need of treatment. SMI is defined as having some time in the past year a diagnosable mental, behavioral, or emotional disorder that met the criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (American Psychiatric Association [APA], 1994), that resulted in functional impairment that substantantially interfered with or limited or more major activities".[3]

Access to Health Care

Studies have reported that access to care continues to be a barrier, particularly to individuals with SMI. According to the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council's thirteenth technical report titled" *Morbidity and Mortality in People with Serious Mental Illness (SMI),* "*Access to physical health care for people with SMI is hindered by both the structure and the under-funding of the publicly support physical health and behavioral health systems of care". Systemic issues include:*

- *Lack of reimbursement for coordinated care across service systems;*
- *Lack of reimbursement for health education, support and family services,*
- *Inadequate and under-skilled case management services to support self-management and linkage to services;*
- *Poor coordination between health care and behavioral health care systems*; *and*
- *Lack of integrated treatment for co-occurring mental health and substance use disorders with lead to inadequate diagnosis and treatment of substance use disorders.*[4]

National Efforts

In July 2003, the President's New Freedom Commission on Mental Health issued its final report, Achieving *the Promise: Transforming Mental Health Care in America.*[5] To achieve the promise, six goals were established. According to the New Freedom Commission, in a transformed mental health system:

- ❖ Americans understand that mental health is essential to overall health;

[3] Epstein J., Barker, P., Vorburger, M., & Murtha, C. (2004). *Serious mental illness and its co-occurrence with substance use disorders, 2002* (DHHS Publication No. SMA 04-3905, Analytic Series A-24). Rockville, MD: Substance Abuse and Mental Health Services Administrations, Office of Applied Studies

[4] *Morbidity and Mortality in People with Serious Mental Illness*, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, October 2006, p.23

[5] The President's New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America, June, 2003.

- ❖ Mental health care is consumer and family driven;
- ❖ Disparities in mental health services is eliminated;
- ❖ Early mental health screening, assessment, and referral to services are common practice;
- ❖ Excellent mental health care is delivered and research is accelerated; and
- ❖ Technology is used to access mental health care and information.

The first of the six goals articulated in the New Freedom Commission report speaks to the heart of the matter. In understanding the goal and to fuel transformation efforts of the mental health system, the report highlights two recommendations: "*1. Advance and implement a national campaign to reduce stigma of seeking care and a national strategy for suicide prevention; 2. Address mental health with the same urgency as physical health".* According to the New Freedom Commission report, "Research demonstrates that mental health is key to overall physical health. Therefore, improving services for individuals with mental illnesses requires paying close attention to how mental health care and general medical care interact. While mental health and physical health are clearly connected, a chasm exists between the mental health care and general health care systems in financing and practice. Primary care providers may lack the necessary time, training, or resources to provide appropriate treatment for mental health problems"[6].

The National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council's thirteenth technical report titled" *Morbidity and Mortality in People with Serious Mental Illness (SMI)"* highlighted several recommendations and solutions to enhance national, state and provider efforts. At the national level the following recommendations are noted:[7]

1) *"Designate the population with SMI as a health disparities population*
   - *Federal designation of people with SMI as a distinct at-risk health disparities population is a key first step followed by the development and adaptation of materials and methods for prevention in this population as well as inclusion in morbidity and mortality surveillance demographics.*
2) *"Adopt ongoing surveillance methods*
   - *Establish a committee at the federal level to recommend changes to national surveillance activities that will incorporate information about the health status in the population.*
3) *Support Education and Advocacy*
   - *Share information widely about physical health risks in persons with SMI to encourage awareness and advocacy. Educate the health care community. Encourage persons served and family members to advocate for wellness approaches as part of recovery.*

[6] The President's New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America, June, 2003

[7] *Morbidity and Mortality in People with Serious Mental Illness*, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, October 2006, p7 - 9

- *Promote adoption of recommendations in the NASMHPD Technical Reports on Polypharmacy and Smoking to implement policies and programs addressing these risk factors.*

State level recommendations include:

1) *Prioritize the public health problem of morbidity and mortality and designate the population with SMI as a priority health disparities population.*
   - *Collect surveillance data on morbidity and mortality in the population with SMI*
   - *Apply a public health approach and population based interventions.*
2) *Improve access to Physical Health Care*
   - *Require, regulate and lead the public behavioral health care system to ensure prevention, screening, and treatment of general health care issues.*
   - *Build adequate capacity to serve the physical health care needs of the SMI population.*
3) *Promote coordinated and integrated mental health and physical health care for persons with SMI*
   - *Utilize the system transformation recommendations from the New Freedom Commission, Institute of Medicine and SAMHSA to achieve a more person-centered mental health system. Specifically implement the following selected recommendations, as identified in the IOM report, and modified to address the morbidity and mortality issues:*
     - *Create high-level mechanisms to improve collaboration and coordination across agencies*
     - *Promote integration of general health care and mental health care records*
     - *Revise laws and other policies to support communication between providers.*
4) *Support education and Advocacy*
   - *Develop and implement toolkits and guidelines to help providers, self-help/peer support groups and families understand how to facilitate healthy choices while promoting personal responsibility.*
   - *Establish training capacity*
   - *Involve academic and association partners in planning and conducting training.*
5) *Address funding*
   - *Assure financing methods for service improvements. Include reimbursement for coordination activities, case management transportation and other supports to ensure access to physical health care services.*
   - *As a health care purchaser, Medicaid should:*
     - *Provide coverage for health education and prevention services (primary prevention) that will reduce or slow the impact of disease for people with SMI.*
     - *Establish rates adequate to assure access to primary care by persons with SMI.*
     - *Cover smoking cessation and weight reduction treatments.*

        - *Use community case management to improve engagement with and access to preventive and primary care.*

6) *Develop a quality improvement (QI) process that supports increased access to physical health care and ensure appropriate prevention, screening and treatment services.*
    - *Establish a system goal for quality health with the same priority as employment, housing or keeping people out of the criminal justice system.*
    - *Join the Medicaid and Public Health agencies at the state level to develop a quality improvement plan to support appropriate screenings, treatment and access to health care for people being served by the public mental health system, whether Medicaid or uninsured".*

As previously mentioned, the team identified additional objectives and recommendations from national and state findings.

Ensure that Primary Care Organization's screen for mental illness as the underlying cause of somatic symptoms

- Development of a screening tool that includes mental health questions as well as the normal somatic questions. The addition of two or three questions is adequate.
- Approximately 27% of those who seek medical care for physical problems suffer from troubled emotions.
- The personal and social cost that result from untreated mental disorders are considerable—similar to those for heart disease and cancer
- Substance abuse—misuse of alcohol, cigarettes and both illegal and legal drugs—is by far the predominant cause of premature and preventable illness, disability and death.

Full knowledge of (or access to) diagnostic criteria for mental disorders

- Everyone needs to be made aware of the things to look for where mental illness is concerned.
- Increase need for training in psychosocial issues, mental health and substance abuse disorders.
- Need for an "integrated" approach in treating all persons – teaching of chronic-care and disease-management for behavioral health disorders.
    - Many of the medications used in treatment of behavioral health disorders have side effects that may trigger somatic issues.
- Need for development of pre-mentoring programs to help primary care providers with less experience in integrated practices.
- Initiate practice-improvement initiatives, peer teaching and mentoring and cross-disciplinary work groups.
- Promote and use research that shows which approaches are most effective in changing provider practices.

Knowledge of appropriate treatments for various mental disorders

- Development continuing education opportunities focused on care integration, behavioral health management approaches, and reimbursement, coding and other documentation issues.
- Collaborative, cross disciplinary meetings between behavioral health and primary care to address gaps in services and promote treatment protocols while adhering to evidence based practices.
- Initiate practice improvement initiatives, peer teaching and mentoring, cross disciplinary work groups
- Keep in mind practitioners must have a strong clinical and practice management leadership skills to serve patient with complicated problems and diverse cultural and socioeconomic backgrounds

Knowledge of side effects and somatic/medical complications (such as diabetes, weight gain, etc.) from medication associated with behavioral health concerns.

- There are several web sites available that practitioners and the general population can search to find the latest updated material.
- Many have "fact sheets" that can be printed and given to the patients so they are aware of the possible side effects of certain medications. Olanzapine a medication used to stabilize a patient with Bipolar Disorders may sometimes cause patients to gain weight.
    - Patients should be educated regarding this side effect as well as ways to counteract this negative outcome so that they may be mentally stable.
    - Physicians caring for their patient need to know this, especially if weight is of concern with patients with cardiac or hypertensive disorders.

Effective and feasible ways to educate patients and family members and encourage them to take responsibility for their somatic and behavioral health care

- Need for increase public awareness to decrease the stigma with mental illness. Local TV/radio stations that broadcast support groups.
- Need for increase support groups for patients with mental illness encouraging them to seek treatment from integrated practice settings that provide holistic treatments.
- Educate the public on the proponents of integration and how correlating effective treatment of psychiatric conditions results in an overall reduction in health care costs.
- According to the Integration of Primary Care and Behavioral Health: Report on a roundtable Discussion: "It is our hope that, rather than being an endpoint, these recommendations will promote ongoing discussion and new initiatives to end the needless health disparities associated with uncoordinated care and failure to provide integrated services."

Recommendations for Integration of Somatic and Behavioral Heath Care within Community Heath Centers: Joint Commission National Patient Safety Goals balanced with the HIPAA Privacy Rule: include

HIPAA Privacy Rule

- Reasonable steps to ensure confidentiality of communications and disclosures must be ensured.
- An individual who believes that the Privacy Rule is not being upheld can file a complaint with the Department of Health and Human Services Office for Civil Rights.

National Patient Safety Goals

- Improve the accuracy of patient identification - Wrong patient errors occur in virtually all aspects of diagnosis and treatment.
- Improve the effectiveness of communication among caregivers – effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces error and results in improved patient safety.
- Improve the Safety of Using Medications – errors, sometimes tragic, have resulted from unsafe practices.
- Reduce the risk of health care-associated infections – a significant percentage of patients who unexpectedly die or suffer major permanent loss of function have health care-associated infections
- Accurately and completely reconcile medications across the continuum of care – patients are at risk during transitions in care (hand-offs) across settings, services, providers, or levels of care.
- Encourage patient's active involvement in their own care as a patient safety strategy – communication with patients and families about all aspects of their care, treatment or services is an important characteristic of a culture of safety.
- The organization identifies safety risk inherent in its patient population – suicide ranks as the eleventh most frequent cause of death in the United States with one person dying from suicide every 16.6 minutes.

Overview of State Public Mental Health System (PMHS)

The Mental Hygiene Administration (MHA) is the agency within the Department of Health and Mental Hygiene responsible for the oversight of public mental health services in Maryland. Maryland operates the majority of its public mental health system under a Medicaid 1115 waiver. The waiver permits the Secretary of DHMH to require that all Medical Assistance (MA) recipients, except certain exempted populations, be enrolled in and receive their somatic care through managed care organizations (MCOs). Waiver-eligible Medical Assistance recipients are enrolled in MCOs under Maryland's HealthChoice program. Under the terms of the waiver, MCOs receive a capitated rate for providing somatic care, substance abuse treatment, and primary mental health care to enrollees. Primary mental health services, as defined by the enabling legislation, means the clinical evaluation and assessment of mental health services needed by an individual and the provision of services or referrals for mental health services as deemed medically appropriate by a primary care provider. Both the MCOs and MHA are required to assure that somatic care and substance abuse treatments are coordinated with mental health care.

Under Maryland's 1115 Medicaid waiver, a redesigned public mental health system (PMHS) was conceptualized. Specialty mental health services - those mental

health services that are beyond primary mental health services - are delivered through a "carve-out" arrangement that manages public mental health funds under a single payor system. The system serves Medicaid recipients and a subset of uninsured individuals who meet medical necessity criteria and financial and/or other specific criteria. The cost of mental health services is subsidized, in whole or in part with State general funds. Medically necessary mental health services are delivered to eligible individuals of all ages through the PMHS.

Prior to the waiver, MHA administered all State funds allocated to it by the legislature for mental health services as well as some federal grant funds, but only a portion of the State and federal Medicaid dollars, specifically money that paid for services under the Medicaid clinic, rehabilitation and targeted case management options. Through implementation of the public mental health system, July 1997, MHA began to administer all State and federal, including Medicaid, funds related to mental health services.

Other Supports

Medicaid is the joint federal and state program that provides health and long term care coverage to low-income individuals. The main low-income populations covered under Medicaid include children and their parents, pregnant women, older adults, and individuals with disabilities. Medicaid also covers Medicare cost-sharing for certain low-income Medicare enrollees.

Federal Medicaid requires coverage of the following services: inpatient and outpatient hospital, physician, nurse midwife and certified nurse practitioner, laboratory and x-ray, nursing home and home health care, rural health and federally qualified health centers, and early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21. EPSDT requires coverage of all medically necessary services, including dental services, for children under age 21. Maryland's Medicaid also covers "optional" services, such as drugs, therapies, medical day care, and personal care. A new Medicaid initiative, Medicaid for Families, which began July 1, 2008, will provide comprehensive health care coverage to parents and other family members caring for children. Eligibility depends on family size and income.

In Maryland, about 80% of Medicaid beneficiaries are in HealthChoice, Maryland Medicaid's mandatory managed care program. Individuals choose a primary care provider (PCP) and enroll in one of seven HealthChoice managed care organizations (MCOs). MCOs provide almost all Medicaid benefits, except for certain "carved-out" services that are provided on a fee-for-service basis. Specialty mental health is a key carve-out service. MCOs also provide additional services. For example, Maryland Medicaid does not cover dental services for adults, but all seven MCOs have opted to offer a dental benefit to their adult enrollees. The State requires MCOs to cover dental services for children and pregnant women.

Certain individuals are not in an MCO and receive their services on a fee-for-service basis. These populations include individuals who are eligible for Medicare, age 65 or over, eligible for Medicaid under a "spend down" category, continuously enrolled over 30 days in a long term care facility, or qualify for and opt to be in the Rare and Expensive Case Management (REM) program.

DHMH promotes coordination of MCO and fee-for-service specialty mental health services. Enrollees can self-refer to the Specialty Mental Health System, and Medicaid regulations state that an MCO or an MCO primary care provider shall refer an enrollee to the Specialty Mental Health System when the MCO PCP cannot meet the enrollee's needs. The regulations also state that an MCO shall cooperate with the Specialty Mental Health System in developing referral procedures and protocols.

Meetings among Medicaid and MHA staff, MCO medical directors, and MAPS-MD medical directors promote coordination. Special needs coordinators at the MCOs currently have access to identified care managers at the ASO, who are specifically commissioned to fulfill this coordinating function. In addition, information on pharmacy utilization is shared across systems. Medicaid receives real-time information on MCO and fee-for-service pharmacy claims in order to prevent drug contraindications at the point of sale. On a monthly basis, Medicaid sends reports to each MCO of their enrollees' fee-for-service mental health drug use, so MCOs and PCPs have information on the mental health drugs their enrollees are taking. In a new initiative, MHA, MA, and the ASO have worked together to include pharmacy data within the ASO's web-based authorization system. Implemented in July 2007, information on drug prescriptions filled by consumers in the PMHS became available through CareConnections. This information is accessible to providers of mental health services. It is available to those providers with existing open authorizations to treat the consumer. The pharmacy data is refreshed monthly and includes prescriptions filled during the 12 months prior to the refresh date. Information is available to MCOs, who can then communicate it to the primary care physicians. The availability of this new module has enhanced service quality and provided a rich resource to enhance data analysis efforts

State and local efforts to reduce emergency room issues:

MHA has altered the previous centralized admission and referral process for emergency departments (ED) to use in locating and accessing State hospital beds. The process now relies heavily on using local systems of care. This change began with the Eastern Shore Hospital managing the requests for admission form eastern shore EDs to Eastern Shore and Upper Shore State hospitals. Finan Center in Western Maryland now directly manages the referral and state hospital admissions for individuals presenting in EDs in Frederick, Washington, Garrett and Allegany counties. Through changing the locus of the admission system to the state hospitals to the region where the service is located, better coordination of care has developed between the community mental health system, core service agencies, local hospitals and the state hospitals. The collaboration will better promote use of alternative services to hospital levels of care and facilitate the discharge of long stay state hospital patients.

MHA also implemented hospital diversion projects with local core service agencies in jurisdictions with the greatest use of state hospitals and purchase of private inpatient psychiatric care. In August 2006, MHA, with Montgomery County CSA, implemented a hospital diversion project for individuals who are uninsured in Montgomery County EDs who were requesting admission to the state hospital. Since MHA had been purchasing care in private psychiatric hospitals for Montgomery County residents due to lack of state hospital beds, MHA agreed to reprogram these funds to provide a comprehensive system designed at diverting inpatient admissions. The Montgomery County Department of Health and Human Services (MCDHHS) crisis system developed evaluation and triage teams that evaluate individuals in the ED who are uninsured and for whom hospitalization is being requested. In addition to the on site evaluation teams, MCDHHS developed and enhanced an array of community services to provide urgent care and treatment for those individuals who do not need inpatient psychiatric care. This includes residential crisis services, residential addictions services, and outpatient mental health and addictions treatment. To date this project has diverted 30% of individuals seen by the MCDHHS diversion team.

The Anne Arundel Mental Health Authority (AAMHA) began its hospital diversion project in April 2007. It expanded upon its current crisis response system to include on site evaluation and triage for Anne Arundel residents who are uninsured in Anne Arundel emergency departments. This project is evaluating, diverting, and referring and accessing care through the mental health and addictions system. AAMHA has worked with the local health department to access addictions treatment through a co-occurring initiative aimed at improving access for both systems of care. This program has diverted an average of 37% of individuals in EDs. This project is also reviewing and coordinating admissions to the Springfield Hospital Center.

The Baltimore Mental Health Systems, Inc. (BMHS) implemented its hospital diversion project in September 2007 expanding the hours and availability of its mobile crisis teams in order to cover the local EDs in Baltimore City. This program has diverted an average of 81% of individuals. In addition to the expansion of the mobile crisis teams, BMHS, through Baltimore Crisis Response System, Inc (BCRI) has expanded the number of residential crisis beds from 12 to 21. These residential crisis services are now located in space at the Walter P. Carter Center. BCRI is managing the Baltimore City admissions for the Walter P. Carter Center. Since BCRI operates substance abuse detoxification beds funded through the Baltimore City Substance Abuse Services, Inc, individuals will have access to services designed as alternatives to hospital level of care.

In FY 2009, MHA plans to implement two additional modified hospital diversion projects in Prince George's and Baltimore counties. In order to better coordinate the efforts of the hospital diversion projects and create learning communities among the projects, MHA convenes a monthly meeting of representatives from the CSAs, state hospitals, and hospital diversion projects. Both projects have successfully reduced the amount of time individuals are waiting for evaluation and treatment in EDs. This is resulting in more comprehensive systems of care and better clinical outcomes for these individuals.

Additionally, the Maryland Health Care Commission (MHCC), in collaboration with the Mental Health Transformation Office, is conducting a study of who is served by the state mental health hospitals, hospital emergency rooms, in-patient psychiatric units and community alternatives. The MHCC has convened a taskforce of interested parties to develop a plan for the continuum of mental health services. The plan shall include a statewide mental health needs assessment of the demand for inpatient hospital services and community-based services and programs needed to prevent or divert patients from requiring inpatient mental health services, including services provided in hospital emergency rooms.[8]

It is also recommended that health clinics pursue the following:

1. Provide culturally and linguistically competent written materials on behavioral health issues in waiting areas of health clinics for patients and family members to take with them. Issues addressed may include the following:
   - Mental Health Diagnoses (and signs and symptoms of each)
   - Names and doses of Medications, side effects, complications, and interactions between multiple medications
   - Resources, therapeutic services and support groups that are available in the community
   - Crisis Resources (hotlines, crisis center, understanding emergency petitioning, etc.)
   - Materials are available through the Mental Health America, The Substance Abuse and Mental Health Services Administration, and the National Alliance on Mental Illness

2. Require that health educators and health clinic nurses receive annual CEUs on behavioral health topics. Trainings might address topics such as dealing with chronic illness or co-occurring disorders. Additionally it is important that healthcare workers understand the disease of addiction and its relationship to prescription drug use (both addictive and non-addictive prescriptions)

3. Partner with community-based behavioral health agencies (such as MHA and/or NAMI) to offer patient education seminars at the clinics and in other accessible locations. These sessions could provide support and mentoring to people with mental illness and their families. Accurate and up-to-date information could be made available in a setting that is safe and non-stigmatizing.

4. Maintain a comprehensive list of behavioral health resources -- beyond referrals to psychiatrists (such as support groups, hotlines, agencies that can serve as ongoing resources such as MHA or NAMI, etc.)

[8] Maryland's FY 2009 Federal Block Grant Application, Mental Hygiene Administration, Office of Planning, Evaluation and Training

5. Encourage family members to participate in support groups, identify a case manager or family mentor / advocate to help motivate the patient and family to comply with recommendations. This could be done formally or informally, through a competent and committed family member or through a community agency.

Other activities on the State and local level to address integrated care include efforts from the Community Behavioral Health Association (CBH) of Maryland. The CBH is the professional association of Maryland's network of community behavioral health programs operating in the public and private sectors. CBH has convened a Task Force on Integrated Care to further address practices and policies related to this issue.

In conclusion:

- There are many studies being conducted that support the integration of health care practices linking behavioral health and primary care services.
- There needs to be increased efforts made by State and Federal Policymakers to decrease the fears of the "stakeholders" of being worse off under a new directive.
- A need for financial incentives to achieve the initiative for integration in the health field
- The shift from the old paradigm: patients with behavioral health needs are treated by alternative providers to the new paradigm patients being treated by one provider that integrates behavioral health with primary care.
- The debate currently on the table is not whether many individuals with behaviors health disorders be treated in a primary care office, but rather how to ensure that they are appropriately treated.
- Improve collaborations between public and private sectors.
- Continue to promote education and wellness programs and healthy living

MID-ATLANITIC HEALTH LEADERSHIP INSTITUTE
TEAM 5
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